

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04110

TO DEPUTY
OR REMOVAL.
FORWARDED TO THE CHIEF MEDICAL EXAMINER'S OFFICE ALONG WITH BURIAL/TRANSPORT PERMIT. FILE PAGES 1 AND 2 WITH THE REGISTRAR PRIOR TO BURIAL, Cremation.

M

4116

1. PLACE OF DEATH
a. COUNTY

Caroline

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural Henderson

c. LENGTH OF STAY IN lb

50 Yrs.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

None

3. NAME OF
DECEASED
(Type or print)

First
Louis

Middle

Last

Antal Sr.

Month
April

Day
9

Year
1961

4. SEX

Male

6. COLOR OR RACE
White

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

8-31-1879

9. AGE (in years
last birthday)

81

yr.

10. IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Retired Farm Owner

10b. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Hungary

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George Antal

14. MOTHER'S MAIDEN NAME

Julia Nemeth

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
(If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Christena Antal Henderson, Maryland

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

331X

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause lost.

DUE TO

(b)

DUE TO

(c)

Cerebral Hemorrhage

INTERVAL BETWEEN
ONSET AND DEATH

immediate

?

?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour
o. m.
p. m.

Month, Day, Year
19

20d. INJURY OCCURRED
White
at work Not white
at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that
death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

ACTUAL
SIGNATURE

Dawson O. George

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

4-10-61

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

4-13-61

22c. NAME OF CEMETERY OR CREMATORIUM

Greensboro

22d. LOCATION (City, town, or county)

(State)

Greensboro, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE

Hawkins Funeral Home, Greensboro, NC

24a. REC'D BY REGISTRAR

DATE APR 12 '61

24b. REGISTRAR'S SIGNATURE

Arthur S. Trahan

M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

(04111)

1. PLACE OF DEATH a. COUNTY Caroline		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Ridgely		c. LENGTH OF STAY IN 1b 53 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> d. STREET ADDRESS None	
3. NAME OF DECEASED (Type or print) Reuben		4. DATE OF DEATH Month 4 Day 30 Year 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-10-1907	
9. AGE (In years last birthday) 55 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer	
11. KIND OF BUSINESS OR INDUSTRY None		12. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Reuben Buckle		14. MOTHER'S MAIDEN NAME Emma Cannon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-07-5514	
17. INFORMANT Eva Buckle Ridgely, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease			
DUE TO Arteriosclerotic Cardiovascular Disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 15 1960 to Apr. 30 1961 that (I) (we) last saw the deceased alive on Apr. 30 1961 and that death occurred at 1:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Charles H. Stonesifer		22b. DATE SIGNED 20	
22c. PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.		22d. ADDRESS Greensboro, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-3-61	
23c. NAME OF CEMETERY OR CREMATORIAL Greensboro		23d. LOCATION (City, town, or county) (State) Greensboro, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulaire		ADDRESS	
		25a. REC'D BY REGISTRAR DATE MAY 5 '61	
		25b. REGISTRAR'S SIGNATURE Charles E. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4118

CERTIFICATE OF DEATH

Reg. Dist. No. 04112

1. PLACE OF DEATH a. COUNTY <i>CAROLINE</i>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>CAROLINE</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RURAL DENTON</i>		c. LENGTH OF STAY IN 1b <i>life</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RURAL DENTON</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) <i>MARY LOUISE COULBY</i>			4. DATE OF DEATH <i>APRIL 26 1961</i>		
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>DEC 6, 1874</i>	9. AGE (In years, last birthday) <i>86</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>home</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>
13. FATHER'S NAME <i>THOMAS F. NORRIS</i>			14. MOTHER'S MAIDEN NAME <i>MARY KELSEY</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 17. INFORMANT <i>NORRIS COULBY DENTON, Md</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>day</i>		
Coronary thrombosis			4 yrs		
Coronary arterio-sclerosis			6 yrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>Aug 4</i> , 19 <i>38</i> to <i>Aug 26</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>Aug 25</i> , 19 <i>61</i> , and that death occurred at <i>8:30 A</i> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>E. Paul Knotts</i>			ADDRESS (Street, city or town, state) <i>406 Market St</i> DATE SIGNED <i>Denton, Md</i>		
PHYSICIAN'S NAME (Type) <i>E. Paul Knotts M.D.</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Apr. 28, 1961</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Springhill</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Knotts</i>			24a. REC'D BY REGISTRAR <i>MAY 2 '61</i>		
			24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knotts</i>		

TO HOSPITAL (ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4113

04113

1. PLACE OF DEATH
a. COUNTY

Caroline

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Linchester

c. LENGTH OF STAY IN 1b

40 yrs

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3. NAME OF
DECEASED
(Type or print)

First

Middle

Edward P Gadow

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

b. STATE

Md

b. COUNTY

Caroline

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Linchester

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?
YES NO

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

Last

4. DATE
OF
DEATH

Month

Dey

Year

April

25

1961

8. DATE OF BIRTH

Mar. 31. 1881

9. AGE (In years
less birthday)

80 yrs.

10. IF UNDER 1 YEAR

Months

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Germany

US

13. FATHER'S NAME

Ferdinand Gadow

14. MOTHER'S MAIDEN NAME

Bates

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

216 38 9064 Mrs. Lena Plutschack Gadow, Preston

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Acute Pulmonary Embolus

INTERVAL BETWEEN
ONSET AND DEATH

minutes

420.0

DUE TO

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Chronic Congestive Arterioleatheritis 5 yr

15 yr

Generalized Arteritis

MEDICAL CERTIFICATION

19. WAS AUTOPSY PERFORMED? YES NO

Carcinoma of Prostate

20e. ACCIDENT WAS UNDERLYING

OR CONTRIBUTING CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour e.m.

p.m.

20d. INJURY OCCURRED

While at work

Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Jan. 1953 to April 25, 1961, that (I) (we) last

saw the deceased alive on April 24, 1961, and that death occurred at 11 A.M. from the causes and on the date stated above.

22a. SIGNATURE

Jay Plummer

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE
SIGNED

22c. PHYSICIAN'S

NAME (Type)

DR. H. B. PLUMMER

22d. ADDRESS

Preston Md

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

Burial Apr. 27, 1961

24 FUNERAL DIRECTOR'S SIGNATURE

J. M. J. Ladd

23c. NAME OF CEMETERY OR CREMATORI

Jr. O. U. A. M.

ADDRESS

23d. LOCATION (City, town or county) (State)

Preston, Md.

25e. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE APR 28 '61

Arthur S. Evans

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4120 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 04114

1. PLACE OF DEATH a. COUNTY		Caroline		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		
b. CITY OR TOWN (If outside corporate limits, write RURAL)		Denton		c. LENGTH OF STAY IN lb life		d. STATE Maryland b. COUNTY Caroline		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Denton		
				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		

3. NAME OF DECEASED (Type or print)		First Marshall	Middle Howard	Last Howard	4. DATE OF DEATH	Month April	Day 7	Year 1961
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 69 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.
M	W	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	Dec. 20 1891				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) day laborer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
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13. FATHER'S NAME Albert Howard	14. MOTHER'S MAIDEN NAME Lucinda Wright	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT Lacy Griffith, Denton, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized arteriosclerosis</i> Years (c) <i>Arteriosclerosis</i> Years	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>								
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ACTUAL SIGNATURE <i>Dawson D. George</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	DATE SIGNED <i>April 7 '61</i>
EXAMINER'S NAME (Type) <i>Dawson D. George</i>		

22a. BURIAL, CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF Apr. 10, 1961	22c. NAME OF CEMETERY OR CREMATORIUM Denton	22d. LOCATION (City, town, or county) Denton Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur Morrison Denton Md.</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE APR 12 '61	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate in pencil, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WEDNESDAY, SEPTEMBER 23, 1942

WEDNESDAY, SEPTEMBER 23, 1942

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04115

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland b. COUNTY Caroline					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg		c. LENGTH OF STAY IN lb 20 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg		d. STREET ADDRESS Reliance Avenue			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Reliance Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Alexander	Middle Hardcastle	Last Lord	4. DATE OF DEATH April 20	Month April	Day 20	Year 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> February 19, 1892	9. AGE (in years from birthday) 69 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Merchant		10b. KIND OF BUSINESS OR INDUSTRY Grocery Store		11. BIRTHPLACE (State or foreign country) Ridgely, Md., R.F.D.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William H. Lord				14. MOTHER'S MAIDEN NAME Wilhelmina Russum					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. No 220-32-0280		17. INFORMANT Mrs. Alexander H. Lord, Federalsburg, Md.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Aclusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Atherosclerosis DUE TO (c)									
INTERVAL BETWEEN ONSET AND DEATH sudden ?									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE Dawson O. George		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) Dawson O. George, M.D.		4-20-61							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 23, 1961		22c. NAME OF CEMETERY OR CREMATORIUM Hill Crest Cemetery		22d. LOCATION (City, town, or county) Federalsburg, Maryland (State)			
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland		ADDRESS J. J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR DATE Apr 25 '61		24b. REGISTRAR'S SIGNATURE John J. Frampton			



TO HOSPITAL: _____ may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4122

CERTIFICATE OF DEATH

04116

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CAROLINE	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	b. COUNTY CAROLINE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DENTON	c. LENGTH OF STAY IN TB	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X DENTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) FLORENCE	First	Middle	Last
4. DATE OF DEATH APR. 15 1961	Month	Day	Year
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR. 22, 1877
9. AGE (In years last birthday) 84 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Delaware	12. CITIZEN OF WHAT COUNTRY USA
13. FATHER'S NAME CHARLES	14. MOTHER'S MAIDEN NAME ELIZABETH [Unknown]		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO.	17. INFORMANT MRS. FLOYD BAKER	Address DENTON, MD
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ADVANCED GENERALIZED ARTERIOSCLEROSIS DUE TO (c)			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NUTRITIONAL ANEMIA			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from Jan. 10, 1961 to Apr. 15, 1961 that I last saw the deceased alive on Apr. 14, 1961 and that death occurred at M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Greensboro, Md.	DATE SIGNED 4-17-61		
ACTUAL SIGNATURE Charles H. Stanesifer M.D.	PHYSICIAN'S NAME (Type) CHARLES H. STANESIFER		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Apr. 18, 1961	22b. DATE THEREOF Apr. 18, 1961	22c. NAME OF CEMETERY OR CREMATORIAL Kensington	22d. LOCATION (City, town, or county) Wilmington, Del.
23. FUNERAL DIRECTOR'S SIGNATURE J. D. [Signature]	ADDRESS 2000 N. Howard Street	24a. REC'D BY REGISTRAR Arthur S. Kline	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4123

CERTIFICATE OF DEATH

Reg. Dist. No.

04117

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
CAROLINE MARYLAND		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b DENTON life	
DENTON		X DENTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
WILLIAM		JOSEPH	WILLIS
4. DATE OF DEATH		Month	Day Year
APRIL 22 1961			
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
M		W	
8. DATE OF BIRTH		9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months Days Hours Min.
JUNE 2, 1915		45 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
MACHINIST		WELL DRILLING	MARYLAND
12. CITIZEN OF WHAT COUNTRY?		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
ROGER WILLIS		SUSIE HUNTER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT
YES WWD			MRS. W.M. WILLIS
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH about a yr	
162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.			
(b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
APRIL 21 1961			DENTON, MD
21. I certify that I attended the deceased from alive on April 22 1961, and that death occurred at 4:30 AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE E. Paul Knotts M.D.		406 Market St	
PHYSICIAN'S NAME (Type)		Denton, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL
Burial		APR 25, 1961	DENTON
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. REC'D BY REGISTRAR DATE APR 27 '61
John W. Knotts, Denton, Md.			24b. REGISTRAR'S SIGNATURE John S. Knotts

CERTIFICATE OF DEATH

REGISTRATION

REGISTRATION NUMBER

NAME

NAME